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The reorganization of the Health Care Financing Administration (HCFA) within the Department of Health, Education, and Welfare (HEW), which has resulted in the placement of Medicaid, Medicare, and quality and standards primarily under the direction of one agency head, should result in improved management of the programs through better coordination of efforts and exchange of information. The organizational structure, including the authorization of specific supergrade positions, is still developing. HCFA requests for supergrade and executive level staff have been cut in half since the initial proposal, and some reductions have occurred since the Subcommittee on Health questioned the matter. The continued split between the Public Health Service and HCFA can be expected to result in problems with respect to the administration and management of the health financing programs authorized by the Social Security Act. There is evidence of duplication and overlapping of staff activities in functional statements issued by HCFA and other elements of HEW. However, most of these duplications were in the area of planning or carrying out evaluations, studies, and research where the identification of precise duplication based on broad functional statements is difficult. The primary areas where real consolidation has occurred are in program integrity and the administration of standards and provider certifications. Little has occurred in other consolidation of Medicaid and Medicare functions presumably because of the major differences in the legislation for the two programs. (SC)

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Statement of
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before the
Subcommittee on Health

Committee on Finance
United States Senate
on
Development and Organization of the
Health Care Financing Administration

Mr. Chairman and Members of the Subcommittee:

We are pleased to appear here today to discuss the results of our review of the development and organization of the Health Care Financing Administration (HCFA) in the Department of Health, Education, and Welfare (HEW).

The Subcommittee asked us to determine if the organization of HCFA had resulted in

- proliferation of supergrades,
- fragmentation of authority and responsibility, and
- proliferation and possible overlapping of staff activities.

We discussed the objectives and effects of the reorganization with high-ranking HEW headquarters officials, some regional office personnel, and with representatives of the Office of Management and Budget and the Civil Service Commission. We reviewed available documentation of staffing patterns--numbers, grade-levels, and position descriptions--before and

after the creation of HCFA. We also discussed the effects of staffing patterns with Civil Service Commission officials.

One problem we had in conducting our review was that not all of the decisions relating to HCFA's organization had been made at the time HCFA was considered as operational on June 20, 1977. Thus, its organization is in a constant state of flux with changes in the organizational elements' responsibilities occurring almost daily.

OBJECTIVES OF HEW'S REORGANIZATION

On March 8, 1977, HEW Secretary Joseph A. Califano, Jr. announced a series of reorganization initiatives designed to (1) streamline HEW operations, (2) improve delivery of services, and (3) reduce opportunities for fraud and abuse.

To accomplish these goals, the HEW consolidated the educational loan programs within the Office of Education and disestablished the Social and Rehabilitation Service (SRS) transferring SRS's income security program (aid to families with dependent children) and related activities to the Social Security Administration (SSA), SRS's social services program to the Office of Human Development (OHD), and SRS's medical assistance program (Medicaid) to the newly established HCFA. In addition to Medicaid, HCFA was given responsibility for administering the Medicare program which was transferred from SSA, and the standards, certification, and professional standards review organization (PSRO) programs which were transferred from the Public Health Service (PHS).

Basically, HCFA received the program responsibilities and most of the personnel of five organizational components, (1) SSA's Bureau of Health

Insurance, (2) the Division of Health Insurance Studies in SSA's Office of Research and Statistics, (3) PHS's Bureau of Quality Assurance, (4) PHS's Office of Long-Term Care, and (5) SRS's Medical Services Administration. HCFA also received about half of SRS's support and staff personnel to perform similar functions for HCFA.

As a result of these transfers of functions, HCFA is now responsible for administering both Medicare and Medicaid and most of the activities which support these two programs. Medicare and Medicaid are similar in many respects, but also differ significantly. For example, both programs usually use the same health facility standards and certification programs, Medicaid payments are limited to Medicare's reimbursement rates, and both programs contract extensively with private companies for claims processing functions. However, Medicare is a Federal program with uniform eligibility and reimbursement criteria nationwide while Medicaid is basically a State program in which the Federal Government sets broad policy and participates in program costs with State governments setting all or some of the eligibility and reimbursement standards. Thus, there is one Medicare program, but 53 Medicaid programs.

The Secretary said an immediate benefit of consolidating Medicare and Medicaid would be an energetic program of reviews to determine major abuses in health care financing programs. He said that hundreds of millions of dollars may be saved through a vigorous program of reviews, audits, and investigations to detect fraud, abuse, and overpayments. Another benefit, he said, would be the simplification and strengthening of health policy development.

We will now address the issues contained in the Subcommittee's request of June 14, 1977.

POSSIBLE PROLIFERATION OF SUPERGRADES

The Subcommittee's letter to us asked a number of questions relating to the supergrade structure of HCFA.

We believe that the issue of supergrade positions can be viewed from two perspectives.

--If the establishment of HCFA is viewed as essentially the merging of four operational components and one staff component, then there has been an increase in the number of requested supergrades. However, this increase has been somewhat reduced since the Subcommittee questioned the issue and the increase could well be reduced further based on Civil Service Commission review of the supergrade justification.

--(On the other hand if the establishment of HCFA is viewed as an integral part of the dissolution of the Social and Rehabilitation Service--which is the hard reality to the people most directly involved--then it could be argued that there could be a net reduction in the number of supergrades; however, if the Congress passes legislation protecting the grades of individuals from adverse actions resulting from reorganizations then the argument for this second view should be modified. In any event, we believe either view is defensible depending upon the perspective.

The first proposal we were able to identify relating to the number of supergrade positions (GS-16-18) for HCFA was one for 49 supergrade and executive level positions (including 10 regional administrators) submitted to HEW's Acting Deputy Assistant Secretary for Management on or about April 8, 1977, in response to the Acting Deputy Assistant Secretary's request for information with which to prepare HEW's annual request for supergrade positions. The 49 positions, according to one official, was arrived at by looking at the positions authorized such other Federal agencies as SRS and the old Office of Economic Opportunity. No analysis of available supergrade positions and of workload was made to determine HCFA's needs for supergrades and the list of 49 was characterized by an official as a "wish list". The Acting Deputy Assistant Secretary rejected this list.

When the Secretary testified before the Subcommittee on June 7, 1977, it was contemplated that HCFA would have 21 supergrades in its headquarters and possibly an additional 5 in its regional offices. At that time, HCFA was also requesting 3 executive level positions. The organization as contemplated about that time is shown on chart number 1.

Since the Secretary's testimony, the number of supergrades being requested by HCFA has been reduced by one, the number of executive level positions has been reduced by one, and the grade level of four positions have been reduced, for example from GS-18 to GS-17. The following table gives by grade the number of executive and supergrade positions requested for HCFA headquarters as of April 8, June 2, and July 11.

	<u>Number requested as of April 8</u>	<u>Number requested as of June 2</u>	<u>Number requested as of July 11</u>
Level IV	1	1	1
Level V	2	2	1
GS-18	7	5	4 ^{a/}
GS-17	10	8	8
GS-16	<u>19</u>	<u>8</u>	<u>8</u>
Total	39	24	22 ^{a/}

^{a/}One of the GS-18 positions is that of Deputy Administrator for Operations. We have been informed that the Administrator does not contemplate filling this position at this time.

Lowering of the supergrade levels will make it more difficult to request additional supergrade positions in the future without first justifying the upgrading of the lowered positions.

In addition to the supergrade positions for HCFA headquarters, requests were also made for regional office supergrades. As of April 8, 10 regional office supergrades were being requested. This was reduced to 5 as of June 2. As of July 11, the Under Secretary had notified HCFA that HEW had approved 5 regional supergrades but that, since supergrade resources were not available, HCFA could not proceed with attempting to obtain authorization for the positions from the Civil Service Commission until further notification.

Mr. Chairman, if the Subcommittee desires, we can provide a list of the executive positions as proposed April 8. We can also provide a list as proposed as of June 2, and as they were proposed July 11 along with the names of the individuals acting in these positions and their former grades

and positions. The organization as contemplated on July 11, 1977, is shown on chart number 2.

When HCFA requested the supergrade and executive level positions, it did not provide the Acting Assistant Secretary for Personnel Administration with proposed staffing charts, evaluation statements, position descriptions, or justifications for the supergrade positions. The Acting Assistant Secretary requires these documents in order to obtain CSC approval for the allocations of the supergrade positions. Therefore, as of July 11, 1977, no supergrade positions had been authorized for HCFA.

As of March 9, 1977, there were 13 supergrade positions authorized for the 5 operating agencies being merged. Overall the net difference between these 13 supergrade positions (including one vacancy) and the 20 positions currently requested for HCFA represents a Deputy Director for Operations which the Administrator does not contemplate filling at this time, an actuary position for which there is some question as to whether the function will remain with SSA, a position for the consolidation of the Program Integrity Function, and an additional supergrade position for the PSRO function. According to HEW, the remaining 3 additional supergrades represent staff and support supergrade positions in the parent organizations of the 5 units which should now be allocated to HCFA to perform its staff and support functions. Since the documentation supporting the request for the supergrade positions was not available, we made no further inquiries into the matter pending submission of the justifications to the Office of

the Secretary and then to the Civil Service Commission. It should be noted that CSC will have to review and approve the positions before they can be authorized by HCFA.

Of the 22 supergrade and executive level positions being requested by HCFA, 16 are line positions and 6 are staff positions. In comparison, SRS had 1 executive level and 11 supergrade line positions, and 5 staff supergrade positions.

Six HEW interviewees we interviewed expressed concern that the HCFA organizational structure was designed to accommodate pre-existing grade structures, protect grade levels for employees below the supergrade level, and/or to provide for future expansion of the number of supergrades. These concerns were based on what these HEW officials perceived as unnecessary layering of supervisory positions, expanded numbers of offices and divisions below the primary executive positions, and and/or broad functional statements for organizational elements. The officials also saw these as possible structural problems which could inhibit policy making and decision making in HCFA.

Additionally, it has been pointed out to us that if the Administration's legislative proposal pertaining to downgrading resulting from reorganization is enacted, it could result in HCFA having more supergrade employees than it has supergrade positions. This could result because the proposal would protect employees from being downgraded because of reorganizations and HCFA has several nonsupergrades acting in supergrade positions while several supergrade employees are not acting in supergrade positions.

Also, we noted that CSC has extended to December 31, 1979, the time HEW has to comply with the HEW classification reviews from February 1974 through 1976, including those for SRS, which reported significant overgrading of positions in grades below the supergrade level. Thus, those SRS employees transferred from SRS to HCFA and to other organizations can already have their grades protected for 2-1/2 years. Also, if H.R. 6953 is enacted, employees whose positions were overgraded and the positions subsequently reduced, would retain their grade-level for as long as they stayed in the downgraded position. When they left the position, the new employee would be at the reduced grade.

As of July 11, 1977, no position management studies had been conducted in HCFA to ensure proper position alignments or to assess potential impact of supergrades and supervisory positions on other positions in the HCFA organization. Additionally, no manpower analyses or work measurement studies have been initiated, although HCFA plans to initiate a manpower analysis of the Office of Personnel in the near future. No technical assistance relating to supergrade positions has been requested from or provided by the Assistant Secretary for Personnel Administration to assure that all procedures prescribed by the Civil Service Commission have been appropriately followed.

If the merger of the five units is viewed as part of the disestablishment of SPS, the number of headquarter supergrades has been reduced by one, calculated as follows:

Before reorganization

<u>Organizations.</u>	<u>Authorized supergrades</u>
SRS (including Medical Services Administration)	16
Bureau of Health Insurance (SSA)	6
Office of Research and Statistics (SSA)	1
Bureau of Quality Assurance (PHS)	2
Office of Long-Term Care (PHS)	1
Total	<u>26</u>

After reorganization

<u>Organizations</u>	<u>Requested supergrades</u>
HCFA	20
SSA	2
OHD	3
Total	<u>25</u>

In addition, SRS had eight regional office GS-16 supergrade positions at the time of the reorganization of which two were vacant. HCFA is presently requesting five regional positions at the GS-16 level, but as noted previously, action to request authorization from the Civil Service Commission has been held in abeyance.

SRS was authorized 16 headquarters supergrade positions at the time it was abolished. Of these, 4 were vacant. We have been informed by HEW that 12 incumbents have been placed in HEW agencies or resigned as follows:

--3 assigned to HCFA,

--3 assigned to Office of Human Development,

--1 assigned to SSA.

--1 detailed to the Office of the Inspector General,

--1 detailed to the Office of the Assistant Secretary for
Management and Budget,

--1 detailed to the Office of Education,

--1 detailed to HCFA, and

--1 is no longer with HEW.

Also, one of the vacant supergrade positions has been assigned to SSA.

DID THE REORGANIZATION RETAIN PRIOR OR RESULT IN
NEW FRAGMENTATION OF AUTHORITY AND RESPONSIBILITY

The Subcommittee's letter to us asked several questions relating to possible fragmentation of authority and responsibility for HCFA programs.

As you requested, we interviewed key HEW personnel about this. We also reviewed available documentation including approved and draft functional statements and delegations of authority.

Most of the officials we talked with felt that the HCFA organization would result in better management of Medicare and Medicaid programs through enhanced and speedier policy and decision making. These improvements were attributed by the officials to the following factors:

- One agency head is now responsible for the operation of Medicare, Medicaid, standards and certification, and quality assurance whereas three agency heads were formerly responsible for these functions.
- For the Medicaid and quality assurance program, the number of bureaucratic layers and coordination points through which decisions had to pass before they were finalized has been reduced.
- Headquarter's offices now believe they have direct line authority over their regional office counterparts thereby ensuring more uniform policy interpretation and guidance to agencies and individuals external to HCFA.
- The program integrity functions of Medicare and Medicaid have been consolidated which should result in better interchange of information and techniques between the programs.
- The consolidation of the standards and quality of care programs with the financing programs in one agency should improve and help make uniform the application of quality assurance programs.

Overall, the officials we interviewed believed that the operation of and policy and decision making for the HCFA programs should be enhanced. The exception was the hospital insurance portion of Medicare which most felt was already well managed and operating efficiently. Most officials stated that some of Medicare's effectiveness in policy making and operations might be lost because of the reorganization. On the other hand, the officials also generally agreed that the other programs would benefit by drawing on Medicare's management capabilities.

Although the officials almost unanimously agreed that the reorganization would improve the management of the health financing programs, they did see several problem areas that could develop. Their views and other information we have gathered relating to these possible problem areas follows.

PSRO and Standards Policy/Operation Split

The reorganization resulted in HCFA having responsibility for operating the PSRO and standards program while PHS retained responsibility for setting policy for these programs. The Secretary in his testimony before this Subcommittee on June 7 gave his rationale for this split. He said that he did not believe he had actually separated policy from operations but rather the intent of the reorganization was to "***retain some element of quality control within the Office of the Assistant Secretary for Health" because PHS "has some programs over which it has control that need quality control"--for example, HMOs and community health centers--and because "the broad medical doctor input was important to have on a continuing basis into [HCFA]." Some officials told us that another reason the Secretary

took this action was to assure the Assistant Secretary for Health would have an important role in national health insurance and to retain certain personnel expertise in PHS.

The Office of Quality Standards is the PHS element that will provide quality assurance policy guidance to HCFA. The functional statement for this office was dated June 19, 1977, and published in the Federal Register on June 28, 1977. The notice in the Federal Register said that PHS's Bureau of Quality Assurance was abolished and all its functions, except for issues relating to coverage of specific procedures and provider proficiency testing, were transferred to HCFA. The notice also established the Office of Quality Standards. Its functional statement states that it provides policy guidelines to HCFA for developing and applying health care standards and that it will review and clear all HCFA regulations in the areas of standards and quality assurance. We interpret this to mean that PHS has retained policy control over the standards and PSRO areas since the office that provides policy guidance and then reviews and clears regulations in effect sets the policy. We also noted that HCFA was not given the opportunity to comment on the final form of this functional statement before it was published. We understand that the Secretary has since asked for HCFA comments on it.

All the HCFA officials we interviewed said they thought problems would arise because of the policy/operation split in the standards and PSRO programs. The degree of perceived problems ranged from minor to major. One PHS official also foresaw major problems.

Several HCFA officials said that to leave the National PSRO Council in PHS while transferring PSRO operations to HCFA would impede policy making and one said it "flies in the face of Senator Talmadge's amendment." The Council is responsible for advising the Secretary on policy matters pertaining to the PSRO programs, providing for the development and distribution of information to PSROs and State-wide PSRO Councils, and reviewing regional norms of medical care used by PSROs. PHS officials said that some of the National PSRO Council members felt the Council should be transferred to HCFA. The PHS officials also said that the American Medical Association and several other provider groups wanted the Council to stay under the jurisdiction of PHS.

One PHS official stated that "Senator Talmadge's concerns over the reorganization are correct because the reorganization is not going to do anything to improve the way in which standards are developed."

Most of the PHS officials and one HCFA official said that they believed only minor problems, if any, would be caused by the split in policy and operational responsibility for standards and PSROs. They said three factors would alleviate the problems:

- The points of view will now be limited to two organizations (PHS and HCFA) whereas before often three points of view existed (PHS, SSA, and SRS).
- PHS will only be involved in broad, long-range policy, primarily involving medical issues, and not operational policy.
- PHS and HCFA personnel have close working relationships and will work out most problems informally.

However, all these officials agreed that there is a large "grey area" between what is definitely operating policy and definitely broad policy and that no formal system for determining when PHS will become involved in policy questions has been developed. These officials also agreed that they were largely depending on the informal organizational or interpersonal relationships to alleviate any problems that might arise.

In our reviews of PSRO program, we have generally found that the track record for program effectiveness has not been good where there is policy setting responsibility without the commensurate line authority to follow through and implement such policies. Specifically, our work in the PSRO program area before the reorganization, when PHS had PSRO policy and direction responsibility but SSA and SRS dictated to a great extent program implementation, showed numerous problems in getting the program moving. My testimony before the Subcommittee on Oversight, House Committee on Ways and Means, on April 4, 1977, which we can provide for the record, listed a number of problems and gave some examples of the problems caused by this split.

Role of Commissioner of Social Security
As Secretary of Boards of Trustees of
the Medicare Trust Funds

Under sections 1817 and 1841 of the Social Security Act, the Commissioner of Social Security has been designated as the Secretary of the Boards of Trustees of the two Medicare Trust Funds. Accordingly, the annual Trust Fund reports required by law, including statements of the actuarial status of the Trust Funds, have been prepared under the direction of SSA's Office of the Actuary.

With the transfer of responsibility for managing the Medicare program from the Commissioner of Social Security to the Administrator of HCFA, we believe it is important that the role of the Commissioner--particularly in the area of providing the actuarial expertise for estimating disbursements from the Trust Funds should be clarified. Because the functional statement of HCFA's Office of Policy, Planning, and Research assumes that HCFA will have its own actuarial capability, although there is some question as to whether it will retain this function, we are concerned about the duplication or overlapping of the actuarial functions unless the Commissioner's responsibilities are clarified.

One alternative would be a statutory change which would designate the Administrator of HCFA as the Secretary of the Medicare Boards of Trustees.

Policy Development Within HCFA

Some of the officials we interviewed believe that problems could arise from HCFA's organizational structure for policy development. Their main concern was that the responsibility for policy development was not clearly delineated between the staff and line offices. It was generally agreed that the staff offices would not get involved in operational-type policy but would instead concentrate on long range policy issues. However, it was recognized that many policy questions are not clearly either operational or long range issues. No formal system has been devised to determine which policies will require staff input and which will not. Most of the officials believed this could be worked out through an informal system.

Another possible problem area in policy development raised by HCFA officials was the role of the Office of the Executive Secretariat. This office will receive and review all policy issues going to the Administrator. Its activities are supposed to ensure that all points of view within HCFA are presented and all pertinent issues raised. Also, the Executive Secretariat will be the point within HCFA of final review and clearance for policies and regulations. The Acting Executive Secretary viewed this review and clearance process as primarily editorial, but with some degree of substantive review. Earlier proposals relating to the functions of the Executive Secretariat saw its function as one of substantive review and formal clearance. HCFA officials expressed concerns that the Executive Secretariat might evolve into something with the powers envisioned for the Office in early versions of its functions. The officials felt that such an evolved organization would greatly impede and hinder HCFA policy making.

HCFA Communications

Historically, the Medicare and Medicaid program heads have been able to issue instructions and communications to carriers, intermediaries, and States. While the draft delegations of authority transfer all of the authority of the old agency head positions to the HCFA bureau heads, some of the HCFA officials we interviewed expressed concern that this may not ultimately be the case. These officials attributed their concerns to the fact that HCFA was considering using an overall directive system which could affect the authority of the program heads to issue instructions.

Also, prior to the reorganization, the BHI Director was authorized to develop and sign correspondence to members of Congress and the public. However, under the reorganization it appears that the Office of the Executive Secretariat, through which all correspondence flows, will make the determination of where incoming correspondence is distributed and who will sign outgoing correspondence. This would seem to limit the authority of the program heads in the correspondence area.

Employee Union Concerns

The president of the union which had the bargaining rights for SRS, Local 41 of the American Federation of Government Employees, sent us a letter, along with a number of documents, in which the union's concerns regarding the reorganization were expressed. Through the letter and discussions with Local 41 officials we were informed that the union believes HEW had violated the union contract and CSC regulations by not consulting and negotiating with the union concerning employee's rights under the reorganization and that the reorganization had resulted in fragmentation of responsibility in the automated management information system approval process for welfare programs.

Regarding management information systems, the union pointed out that whereas SRS had consolidated the approval process for such systems for AFDC, Medicaid, and social services in one office (the Office of Information Systems), the approval process was now split three ways: (1) SSA for AFDC systems, (2) HCFA for Medicaid systems, and (3) OHD for social systems. The union expressed the view that this would cause hardships on the States and long delays in obtaining system approval since often all three types

of management information systems are combined in one but would have to be sent to three agencies.

Mr. Chairman, if the Subcommittee wishes, we will provide the letter from the President of Local 41 for the record.

DOES THE REORGANIZATION PERMIT PROLIFERATION
AND OVERLAPPING OF STAFF ACTIVITIES

Mr. Chairman, your letter to us also posed several questions regarding proliferation and possible overlapping of staff activities. More specifically, we were requested to identify any evidence of duplication or overlapping of stated functions between HCFA's organizational elements and other similar HEW organizational elements, as well as to identify any evidence of duplication or overlap between the various offices and bureaus within the Health Care Financing Administration. As you requested, we reviewed functional statements of all HCFA and of other relevant HEW organizational components. Many of the HCFA functional statements have not been approved and were, therefore, still draft documents.

Evidence of Overlapping of Functions
Between Organizational Components of
HCFA and Other Organizations Within HEW

In addition to the question of whether the actuarial expertise should be with the Commissioner of Social Security as Secretary of the Boards of Trustees of the Medicare Trust Funds, or with the Administrator of HCFA as operating head of the Medicare program, we observed the following examples where the language of the functional statements of HCFA organizational components were similar to the stated functions of other organizations.

1. The Deputy Assistant Secretary for Planning and Evaluation (Health) has a Division of Health Financing and Cost Analysis which is charged with performing quantitative studies and evaluations of Medicare and Medicaid including formulating and analyzing alternative legislative proposals, and evaluating the efficiency of existing and potential programs in terms of costs, effectiveness, and economic impact.

HCFA's Office of Policy, Planning and Research has an Office of Legislative Planning which also develops and evaluates recommendations concerning legislative proposals for changes in health care financing. Its Office of Research is supposed to direct the development and conduct of research concerning the impact of Medicare and Medicaid on the health care industry, program beneficiaries, and providers. Its Office of Policy Analysis is supposed to direct evaluations aimed at assessing the effectiveness of the Medicare and Medicaid programs and policies.

2. The National Center for Health Statistics includes a Health Economics Analysis Branch in its Division of Analysis which is charged with conducting analysis of the supply and demand for health services, factors effecting costs and the impact of costs on the availability of supply and the characteristics of demands and the impact of financing arrangements. HCFA's Office of Policy, Planning, and Research includes a Division of Economic

Analysis which is supposed to conduct research on factors which affect the demand and supply of health care services.

3. In addition to sponsoring or conducting reimbursement studies--which many components of HEW are involved in--the National Center for Health Services Research is responsible for analyzing alternatives for national health insurance, testing different options and evaluating the impact of different approaches. HCFA's Office of Policy, Planning, and Research is charged with developing and maintaining a simulation model to assess the economic impact of national health insurance proposals.

Evidence of Overlapping of Functions
Between Organizational Components
Within HCFA

We observed the following examples in the functional statements of various HCFA organizational components in which there were marked similarities in stated functions.

1. End-State Renal Disease - The 1972 amendments extended Medicare coverage to insured individuals and their dependents who are afflicted with end-stage renal disease. Currently, about 36,000 people are receiving Medicare benefits totaling about \$600 million annually.

In addition to Medicare operating and policy divisions involved in the day-to-day development of cost report forms and overseeing the payment of bills for renal disease services by intermediaries and carriers, at least four HCFA or PHS offices (Medicare's Division of Special Operations;

the Office of Policy, Planning, and Research's Division of Health Systems and Special Studies; the Bureau of Health Standards and Quality's End-Stage Renal Disease Staff; and PHS's Office of Quality Standards) have responsibility for studying, monitoring, coordinating, or directing this program.

2. Reimbursement Studies - The HCFA's Office of Reimbursement Practices (and Cost Containment) is charged with the responsibility for examining and studying existing and proposed reimbursement policies utilized by the various HCFA programs. Additionally, it is anticipated that this Office will carry out cost containment functions if Congress passes the proposed cost containment legislation. This office is also charged with examining and ascertaining potential alternatives for reimbursement mechanisms and processes, as well as analyzing the impact of these alternatives on the health care community and on the objectives and financing of programs. This Office, as of July 8, 1977, had no staff.

In addition to the Office of Reimbursement Practices (and Cost Containment) which has line responsibility for studying reimbursement policies, HCFA's Office of Policy, Planning, and Research, with staff responsibility for studying reimbursement policies, has five organizational components which perform reimbursement studies. More specifically, this policy group's Office of Demonstrations and Evaluations houses four of these organizational components--i.e., the Division of Long-Term Care Experimentation, Division of Hospital Experimentation, Division of Health Systems and Special Studies, and the Division of Evaluation. All four divisions study alternative reimbursement mechanisms and the achievement of cost containment and cost effective

alternatives. There also is a separately identifiable unit, the Division of Reimbursement Studies, in the Office of Research which assesses the implications of alternative reimbursement methods for providers (including hospitals, long-term care facilities, ambulatory care centers, physicians, physician extenders, etc.) All five divisions are charged with making recommendations for modification of existing program reimbursement policy and legislation.

In addition to these organizational components, HCFA's Medicare Bureau contains a unit, the Division of Provider and Medical Services Policy, which also evaluates and studies reimbursement policies of provider services under Part B, including those for services provided by HMOs, Group Prepaid Practice Plans, and ambulatory care centers.

3. Systems Development Pertaining to Measuring and Analyzing Fraud and Abuse - The Office of Program Integrity in HCFA is charged with planning, administering, and assessing programs designed to prevent fraud and abuse in the Medicare and Medicaid programs. It develops and applies systems designed to measure and analyze the level and nature of improper expenditures attributable to fraud and abuse.

However, there are two organizational elements in HCFA's Office of Policy, Planning, and Research which are expected to perform similar functions. The Division of Statistical Methods is charged with the function of carrying out sample surveys dealing with overpayments and fraud cases. Additionally, the Division of Health Systems and Special Studies directs the development of cross-cutting special studies in the minimization of fraud and abuse.

4. Personnel Management - The functions for HCFA's Office of Personnel include providing the overall directions for the following personnel management activities: recruitment and placement, employee and labor relations, employee development and training, and special employee development activities. However, two HCFA program bureaus apparently are charged with performing the same functions.

The Medicare Bureau's Office of Central Operations includes a Division of Management which is expected to conduct a manpower management program encompassing recruitment and placement, employee development, fair employment, and employee-management relations and to direct and implement the Bureau's training program for employee development. Similarly, the functions to be performed by the Health Standards and Quality Bureau's Office of Program Support include providing the administrative services in personnel management and acquiring and allocating staff resources.

Are There Opportunities to Combine
or Consolidate Any of the Offices or
Divisions of the New Organization?

Based on our analysis of proposed statements of functions for HCFA, we believe that there are at least five opportunities for combining functions or consolidating organizational components. Specifically, these opportunities are:

1. End-Stage Renal Disease - The statement of function for the End-Stage Renal Disease Staff identifies 10 functions and activities which may be categorized into 3 major areas--i.e., (1) planning and special studies (2) operations such as monitoring performance and operating a medical information system, and (3) quality assurance.

In view of the three categories of functions in this organizational component and since other HCFA and PHS components are involved in these three types of functions, we believe that such a component could be abolished and its functions be transferred to HCFA components whose mission statement indicate they are doing the same thing--i.e., the planning and studying functions should be transferred to the Office of Policy, Planning, and Research, all operational functions transferred to the Medicare Bureau, and all quality assessment functions be combined with the Health Standards and Quality Bureau's regular quality control functions.

2. Reimbursement Studies - Because the functional statements indicate that there are six other components of HCFA engaged in reimbursement studies and because the Office of Reimbursement Practices had no staff assigned as of July 8, 1977, we believe that the organization could be abolished pending legislative action to establish a cost containment program for hospitals at which time a separate organizational unit reporting directly to the HCFA Administrator would probably be justified to plan and implement such a new program to minimize disturbing ongoing operations. Also, the functional statement for the Medicare Bureau's Division of Provider and Medical Services should be revised to eliminate the reimbursement studies function.

3. Surveys and Studies Pertaining to Fraud and Abuse - Since the functions for program integrity have been centralized in the Office of Program Integrity, we feel that the sample survey and special studies functions related to fraud and abuse, which are currently located in the Office of Policy, Planning, and Research should be eliminated, since the Office of Program Integrity is already supposed to be performing these functions.

4. Personnel Management - Based on our discussion with HCFA officials and relevant documents, we understand that the functions for personnel management are to be centralized in the Office of Personnel. However, our observation of functional statements for two bureaus--i.e., Medicare and Health Standards and Quality--indicate that the two bureaus are sharing the personnel management functions of the Office of Personnel. While we have no particular preference on the issue of centralization or decentralization of personnel activities, it seems it should be one way or the other.

5. Office of Policy, Planning, and Research - As indicated by the chart, this organization of about 200 people primarily consisting of the nucleus of one division of SSA's Office of Research and Statistics, now includes 6 offices and 12 divisions. We believe various consolidations could be made particularly at the division level to eliminate apparent overlapping of functions and to avoid the appearance that the Office has been structured to accommodate a particular GS grade structure.

CONCLUSIONS

In summary, we believe that the following overall conclusions can be drawn from our limited review.

--Because the organizational structure including the authorization of specific supergrade positions is still developing, it is hard to draw any hard and fast conclusions. Nevertheless, HCFA's requests for numbers of supergrade and executive level staff has been cut in half since the initial proposal and some reductions have occurred since the Subcommittee questioned the matter.

--Many of the HCFA and PHS officials we interviewed foresaw problems with the continued split between PHS and HCFA with respect to administering or managing the Health Financing programs authorized by the Social Security Act. In fact most acknowledged that the formal structure would not resolve the prior problems but that they were assuming that informal arrangements and the goodwill of the people involved would overcome those difficulties. However, the manner in which the PHS functional statement of June 19, 1977, was published--without formal or informal comment or concurrence from HCFA--raises questions as to the validity of this assumption.

--We can see evidence of duplication and overlapping based on HCFA functional statements and those of other elements of HEW. Most, however, were in the area of planning or carrying out evaluations, studies and research where the identification of precise duplication based on broad functional statements is very difficult. We have identified specific boxes on HCFA's organization chart which could be consolidated or eliminated and we have communicated our conclusions to HCFA management.

--Finally, the primary areas where real consolidation has occurred is in program integrity and the administration of standards and provider certifications. Little other consolidation of Medicaid and Medicare functions has occurred, presumably because of the major differences in the legislation for the two programs.

Overall, we believe that just the fact that Medicare, Medicaid, and quality and standards have been placed primarily under the direction of one

agency head should result in improved management of the programs through better coordination of efforts and exchange of information. Hopefully, HCFA's organization as presently conceived, and as it will evolve over the years, will add to and not detract from this basic plus for program management.